The Louisiana Behavioral Health Partnership

Statewide Management Organization (SMO)

Magellan Behavioral Health of Louisiana, Inc.

MAGELLAN HEALTH SERVICES®

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Agenda

1. Overview: Magellan basics
2. Clinical overview
3. Credentialing 101
4. Accreditation 101 – CARF and COA
5. Claims tips and EDI
6. Outcomes and provider profiles
7. Quality overview
    - Records requirements
    - Fraud, waste and abuse
8. Louisiana training and technical assistance center
9. Clinical advisor overview

Magellan Basics

MAGELLAN HEALTH SERVICES®
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Magellan Health Services

- A specialty health care management company that delivers **innovative** solutions in collaboration with government agencies, health plans, corporations and their members nationwide.
- Specializing in managing behavioral health care, diagnostic imaging, specialty pharmaceutical services and providing pharmacy benefit administration, we **partner** with clients, providers, members and other stakeholders within our health care communities.
- 32 million covered lives for behavioral health, with more than three million covered lives through public sector contracts
- 15 state/county behavioral health contracts in seven states (Arizona, Florida, Iowa, Louisiana, Nebraska, New York, and Pennsylvania)

Magellan Public Sector Overview

Public Sector Programs

Total Public Sector Customers	15
Covered Membership	3 Million

Public Sector Service Centers

Miami, Florida	Bethlehem, Pennsylvania
West Des Moines, Iowa	Newtown, Pennsylvania
Lincoln, Nebraska	Phoenix, Arizona
Baton Rouge & Shreveport, Louisiana	Syracuse, NY

Our Principles

At Magellan, we support a philosophy of wellness that focuses on personal strengths, building hope and offering choices.

Resiliency
We believe that all people have qualities that enable us to rebound from adversity, trauma, tragedy, or other stresses and to go on with life with a sense of mastery, competency and hope.

Recovery
We believe that all people living with behavioral health conditions have the capacity to learn, grow and change, and can achieve a life filled with meaning and purpose.

Cultural Competency
We work to provide care and services that recognize the diverse backgrounds of the individuals and families we serve. Our strategies acknowledge and respect the behavior, ideas, attitudes, values, beliefs and language of an individual or group of people.

Network Development Begins with Partnership

Magellan's approach to network development on behalf of the Louisiana Behavioral Health Partnership (LBHP) will be to implement a regional, strengths based, multi-year plan that is focused on increasing access, enhancing quality, expanding choice and improving consumer experience

- Our approach is to "meet providers where they are" and deliver the necessary support to assist with transition to a managed care model
- One example: Magellan will provide technical and financial support to help providers obtain accreditation
- We see the provider network as a critical asset based on collaboration and partnership around improved outcomes for consumers, not as a commodity

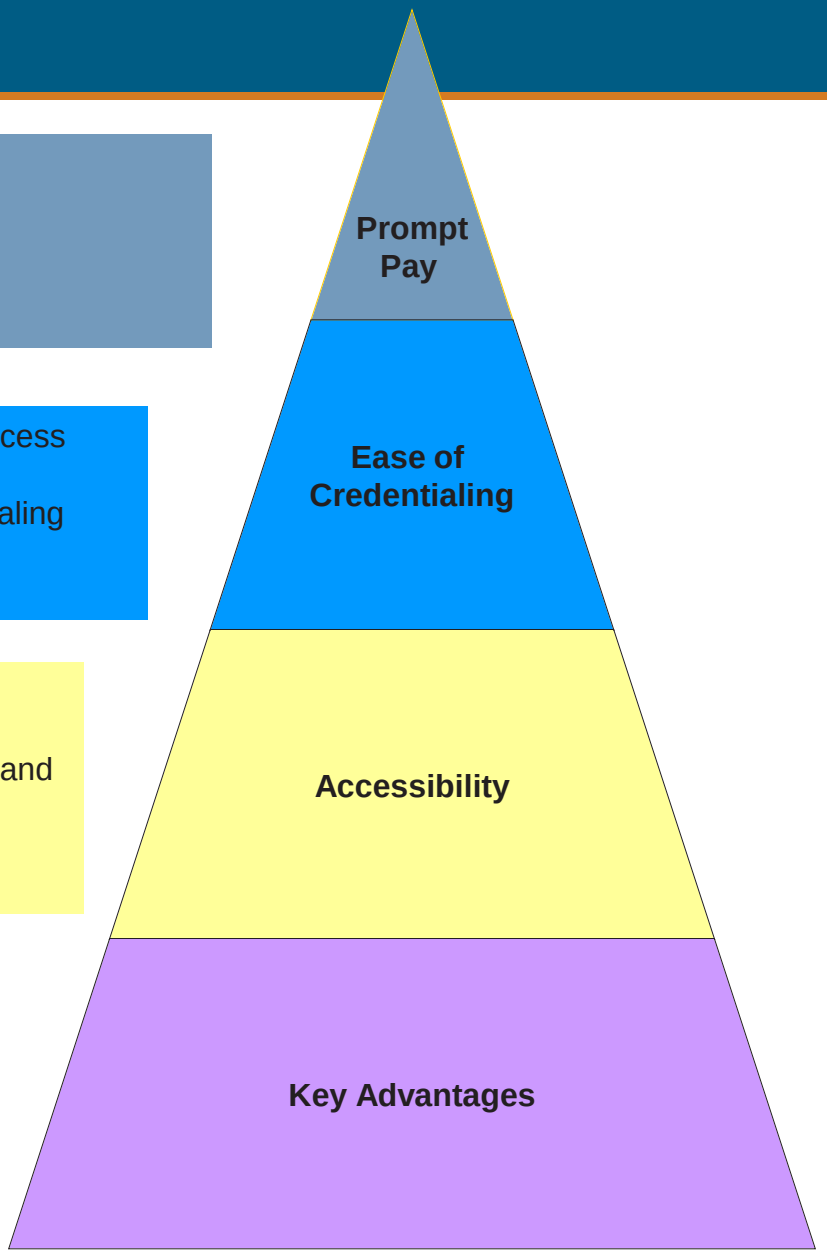
Partnering with providers

- 99.1% claims paid within 14 days
- 99.9% claims paid within 30 days
- Payment accuracy 99.5%
- 91% provider satisfaction with the accuracy of claims paid

- 93% provider satisfaction with the contracting/credentialing process
- Average application processing time 45 days or less
- Uniform Credentialing Data Source (CAQH), online re-credentialing applications or paper applications accepted

- 90% provider overall satisfaction with the services provided by Magellan
- Local provider relations team dedicated to support recruitment and servicing
- Comprehensive suite of Web self-service tools available at: www.MagellanHealth.com/provider

- Free online CEUs for in-network providers
- Web-based outcomes assessment tools and reporting to monitor patient progress
- Access to corporate discounts on office supplies



Transformation Milestones

Year One Objectives and Milestones – Establishing the Baseline:

- Contract with and credential a stable, comprehensive statewide network
- Implement an efficient claims system that pays providers accurately and on time
- Begin to build out the crisis system and expand the network to include alternatives to inpatient care
- Develop consensus, establish baseline measures and begin provider profiling

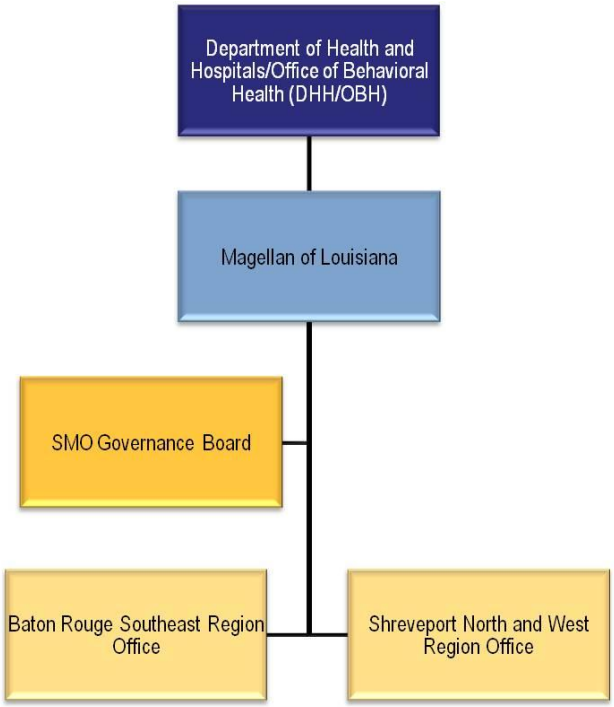
Year Two Objectives and Milestones – Raising the Bar:

- Complete the crisis system build out in all regions.
- Assist providers to ensure all organizations obtain accreditation within 18 months of contract start
- Expand evidence based practice (EBP) capacity through learning and technical assistance

Year Three Objectives and Milestones – Realizing the Vision:

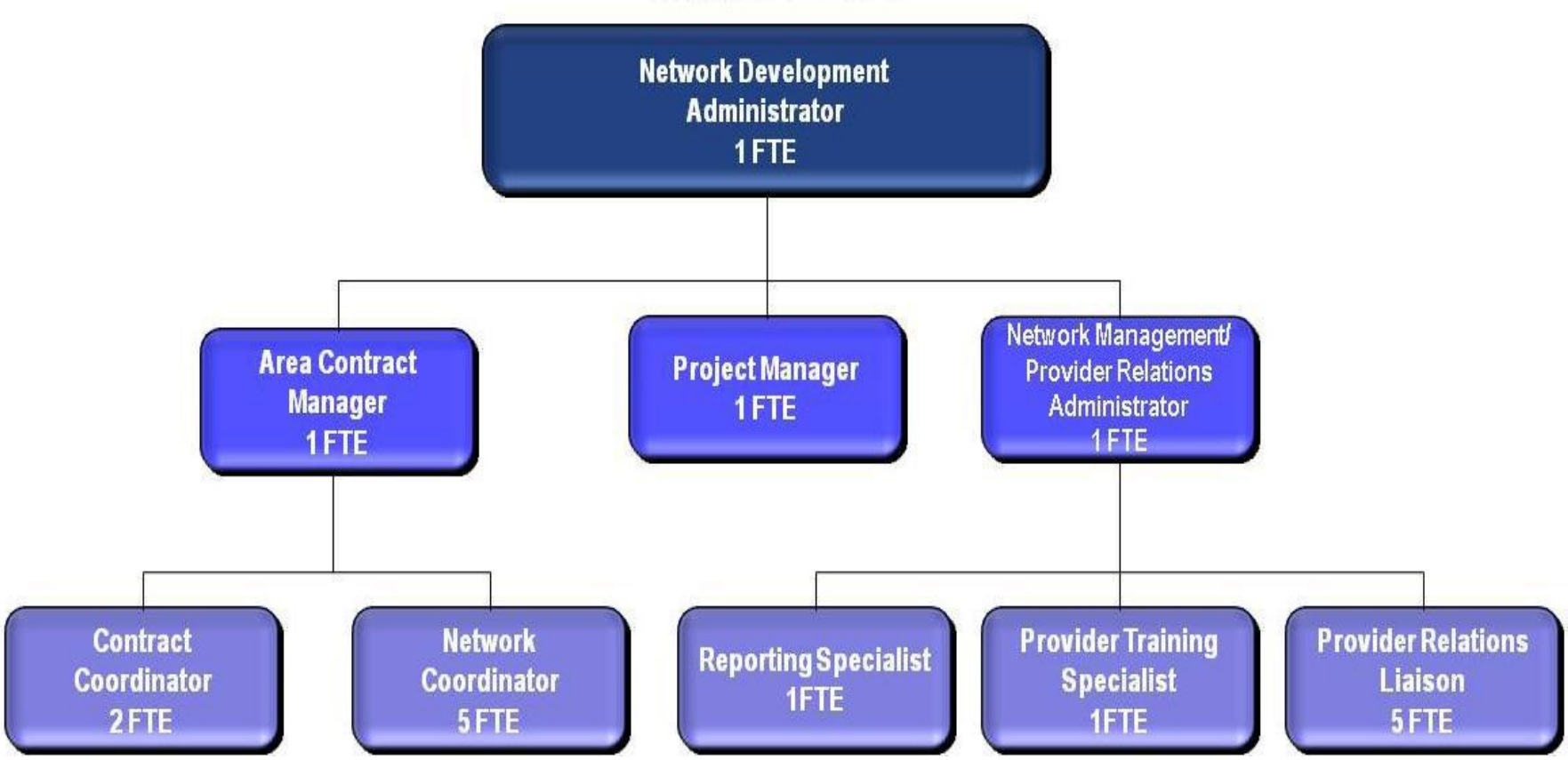
- Move definitively from provider management to provider oversight and partnership
- Consider alternative reimbursement models; pay-for-performance initiatives (such as Partners in Care); and creative provider partnerships
- Review and analyze program data to identify additional network EBPs, and develop a strategy to implement them in targeted locations

Magellan of Louisiana Structure



Governance Board Representation	
Community Representation	**Magellan Representation**
LGE Representative	Chief Executive Officer
Child and Youth Provider Representative	Chief Medical Officer
Adult Provider Representative	Chief Operations Officer
Peer/Consumer	Vice President, System Transformation
Parent/Family Member	Quality Management Administrator
Community Stakeholder at Large	Network Development Administrator

Network Department Structure



Key Information

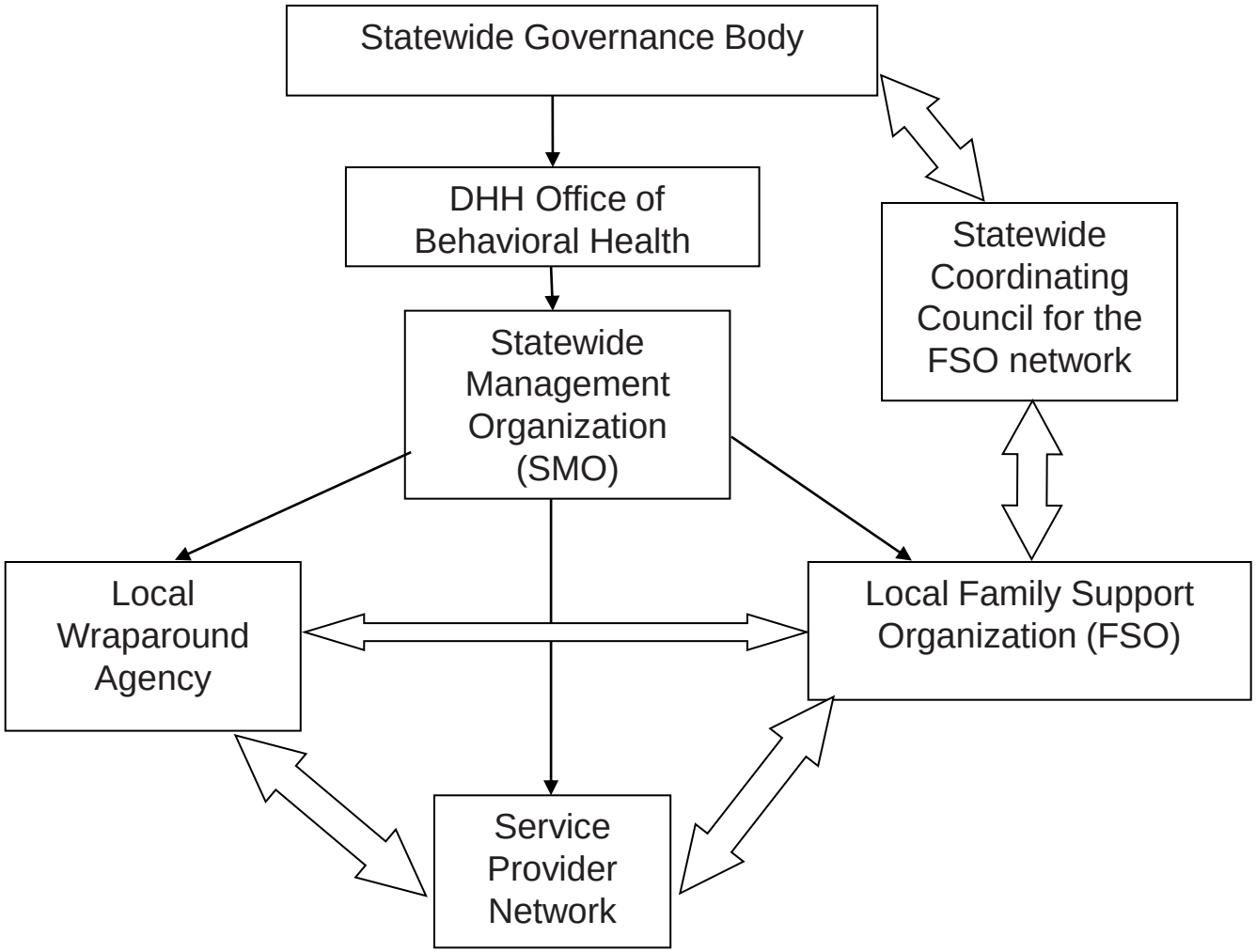
- **Go-live date**: March 1, 2012
- **Main office location**: Baton Rouge
- **Satellite office location**: Shreveport
- **Hours of Operation**: 24/7 in Louisiana
- **Provider Service Line**: 1-800-788-4005
- **E-mail questions**: LAProviderQuestions@MagellanHealth.com

Functions of the SMO

*The contracted statewide management organization (SMO) will serve as the single experienced behavioral health entity, whose role is to provide the following key management functions:

- Member services (24/7 toll free access)
- Referral to providers, or for CSoC- to wraparound agencies
- Utilization management- manage and approve services for participants; prior authorize (when needed)
- Training
- Quality management functions and reporting
- Pay claims
- Provider network management: credential, contract, train, monitor, and ensure compliance from the provider network

Statewide Management Organization Coordinated System of Care Structure



Medicaid Network Provider Participation

- **Facilities**
  - All facilities must have Medicaid number.
  - All facilities must be contracted with Magellan.

- **Providers**
  - Psychiatrists must have a Medicaid number and must be contracted with Magellan.
  - Psychologists must have a Medicaid number and must be contracted with Magellan.
  - Master's-level clinicians must have a Medicaid number and must be contracted with Magellan.

Clinical Overview

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Clinical Philosophy

- Quality services
- Cost effective
- Outcomes
- Recovery and resiliency focused
- Individualized treatment
- “Medically necessary”
- The right treatment in the right amount at the right time

Membership and Service Array

- Nine sub-populations covered
  - Medicaid Adult/Children
  - CSoC Children
  - Adults eligible for 1915(i)
  - Medically Needy
  - CHIP
  - OBH Adult/Children
  - OJJ/DCFS Children
- Screening for CSoC and 1915(i)
- Range of covered services dependent on sub-population

Service Manual

- Inpatient psychiatric
- Psychiatric residential treatment facility for under 21
- Therapeutic group home for under 21
- Mental health rehabilitation services
  - Community psychiatric support and treatment
  - Psychosocial rehabilitation
  - Crisis intervention
- Detoxification and rehabilitation substance abuse
- Outpatient
- CSoC services

Service Manual (cont.)

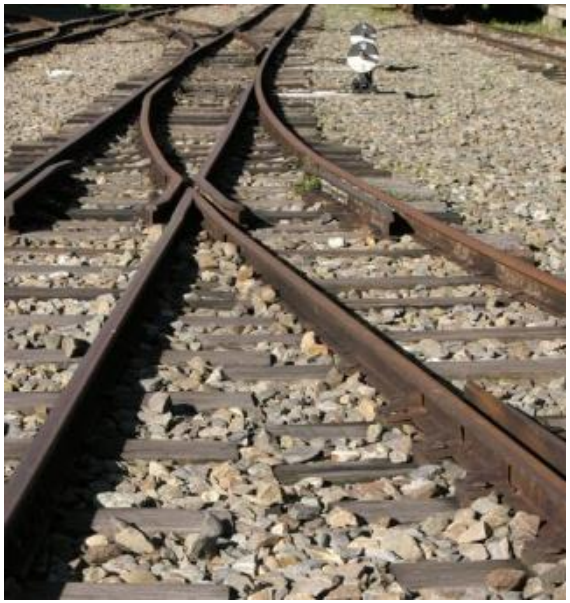
- CSoC Services
  - Parent support and training
  - Youth support and training
  - Independent living/skills building
  - Short term respite
  - Crisis stabilization

Access

- How do individuals obtain help?
  - **“No Wrong Door”**
  - Call center 24/7: Provider search database
  - Website: Provider directory
  - Member Handbook
  - Referral process: self, provider, any concerned stakeholder
  - Transition plan for existing behavioral health recipients

Clinical Transition

- Guiding Principle: no disruption or interruption in service
- Outpatient
- Intermediate levels of care
- Higher levels of care



Authorization of Services

- Based on medical necessity
- Telephonic transitioning toward Electronic Authorization Process
- CaseLogix
- Transition of currently authorized services

Utilization Management

- Office Locations
  - Baton Rouge
  - Shreveport (teams; BR and Shreveport)
- UM Teams
- Activities
  - Authorization, quality oversight, care coordination, discharge and aftercare planning

Recovery/Resiliency Care Management (RCM)

- Intensive care management
- Multiple inpatient admissions or frequent use of crisis services
- CSoC children transitioning home
- Children age 12 and under who are hospitalized
- Co-morbid chronic/severe physical health
- Pregnant women who abuse substances; individuals who use IV drugs
- Individuals identified by providers, WAAs, LGEs as needing intensive care management
- Joint treatment planning
- Peer specialist

Credentialing

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Credentialing Overview

- Credentialing is the process we use to verify a practitioner's or organization's credentials
- Magellan credentials providers every three years, in accordance with NCQA requirements
- The credentialing process includes: Primary Source Verification (PSV) and Regional Network Credentialing Committee (RNCC) review
- Magellan will process all credentialing applications within 180 days or in accordance with applicable state or client company guidelines

Credentialing Overview

- After credentials pass PSV, the application is sent to the regional RNCC meeting consisting of Magellan clinical staff and professional peers
- The local RNCC reviews completed credentialing applications and makes the determination for network inclusion
- For organizations, Section B of the credentialing application must be completed for each service location.
- Copies of the following must be included:
  - Applicable state and federal licenses and certificates, including CMS certification if applicable
  - Copies of any accreditations: Joint Commission, CARF, COA, AOA, AAAHC
  - Copy of most recent state site visit- if not accredited
  - Staff roster

Credentialing Overview

- Complete and return completed credentialing application to Magellan for processing
- For practitioners the average credentialing turn around time is 30-45 days
- For organizations the average credentialing turn around time is 20-30 days
- All credentialing applications must be completed in full and requested documentation attached for the application to be processed.
- If you have not received your credentialing packet, please see a Magellan representative at the end of this meeting.
- *Re-credentialing is completed every three years. You will be notified when you need to start the process, so please read all correspondence you receive from Magellan.

Contracting Overview

Once the credentialing process is complete, and the contracting documents are received, we will execute all practitioner/ organization contracting documents

We are still in the process of finalizing contract documents

The contract documents will include a Magellan provider agreement, Medicaid addendum, and reimbursement schedules.

We will give each provider two copies of the contract documents for signature, once executed an original copy will be returned to the provider for their records.

Contracting Overview

To be eligible for referrals and reimbursement for covered services rendered to eligible members, each provider must sign a Magellan provider participation contract agreeing to comply with Magellan's policies, procedures, and guidelines.

Providers are contracted as individual practitioners, groups or organizations

- **Individual Practitioners:** To be a network provider, individual providers must be both *credentialed* and *contracted* by Magellan. Individuals must also be enrolled in Medicaid
- **Group Providers:** Magellan *contracts* directly with the group entity. The group must be contracted with Magellan AND the practitioners within the group must be individually credentialed by Magellan in order to be referral eligible
- **Organizations:** To be a network provider, organizations must hold an active license through DHH and be credentialed by Magellan. Organizations must also be enrolled in Medicaid. Practitioners within an organization are <u>not</u> individually credentialed, only the organization itself.

Accreditation

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Accreditation Overview

Provider accreditation for organizations

- All organizations will be required to obtain accreditation within 18 months from contract start date of March 1, 2012
- Accreditation bodies – Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), and the Joint Commission
- Support providers to obtain accreditation within 18 month timeframe

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Who We Are

CARF's Mission:

To promote the quality, value and optimal outcomes of services through a consultative accreditation process, that centers on enhancing the lives of the persons served.

CARF Values and Principles

- All persons have the right to be treated with dignity and respect.
- All persons should have access to needed services that achieve optimal outcomes.
- All persons should be empowered to exercise informed choice and involved in all aspects of services (moral owners of CARF).

FOCUS

- Strengths, abilities, needs and preferences
- Cultural competency in all activities and associations
- Individualized services with goals that are meaningful to a person's quality of life
- Health and wellness, prevention/intervention or rehabilitation/recovery

CARF Overview

- Private non-profit established in 1966
- Recognized in approximately 48 states under mandated or “deemed” status legislation/regulatory policy.
- Standards apply to small organizations in rural areas as well as large or urban.
- 1,400 volunteer surveyors in U.S. and Canada.
- Approximately 100 CARF staff members

CARF Accreditation Areas

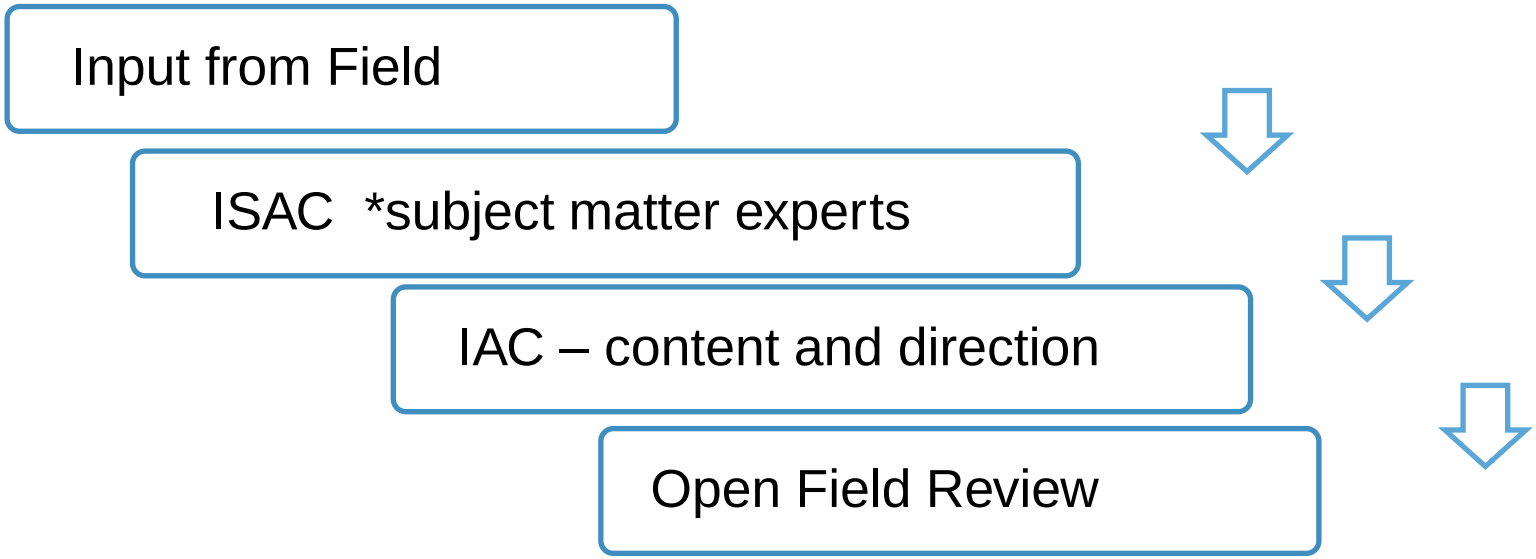
- Child and youth services
- Behavioral health (OTP)
- Employment and community services
- Aging services (CCAC)
- Medical rehabilitation
- Business services management network
- DMEPOS
- Vision rehabilitation services
- One-stop career centers

CARF – Experience by Numbers

More than 8 million person served

- More than 6,300 organizations have CARF accredited programs.
  - 98 organizations are accredited in Louisiana
- More than 47,400 individual programs have CARF accreditation.
  - 386 programs are accredited in Louisiana

Standards Development Process



Annual Review / Periodic Revision

New Standards Manuals are released every calendar year and become effective from July 1 – June 30.

Principles of the Standards

Achievable	• Benchmarks that can be achieved by competent providers
Consensual	• Reflect field consensus
Efficient	• CARF controls the costs of standards development
Cost Effective	• Positive relationship between development and implementation
Non-prescriptive	• Leaves the organization free to meet the standards in its own manner
Practical	• Grounded in day to-day world of service delivery
Relevant	• Makes sense to those who implement the standards
State-of-the-Art	• Guided by Evidenced Based Practice

A Typical Standard

Intent

Intent Statement

The leadership has a working knowledge of what needs to be done to promote an accessible setting. The leadership is able to discuss plans to improve accessibility and remove barriers. Organizations address accessibility issues in order to:

Enhance the quality of life for those served in their programs …

Standard (bold)

Suggested

1.B.1. The leadership demonstrates accessibility planning that address the needs of the:

a. Persons served.

b. Personnel.

c. Other stakeholders.

Examples

Examples of conformance may be found in minutes of meetings where analysis, action planning, and goals are established; in conversations with stakeholders; in focus groups and council meetings…

Check the Glossary

Accreditation Conditions

To be eligible, to maintain, or retain accreditation…

- Use of standards for a minimum of six months
- On site, during survey, must allow surveyors to review records, documentation and interview persons served
- Send quality improvement plan within 90 days after receipt of outcome
- Annual conformance to quality report

Steps to Accreditation

STEP	PROCESS	TIME
1	Consult with CARF Resource Specialist	1½ - 1 year prior to survey
2	Conduct a self –evaluation ***	6 months (suggest 9)
3	Submit Intent to Survey	4 months (suggest 6)
4	CARF Invoice fee (based on # of surveyors / days)	45 days after receiving Intent
5	Survey team selected	Notice 30 days prior to survey
6	Survey	
7	Outcome rendered (email report)	6-8 weeks after survey
8	QIP Submitted	90/45 days after award
9	ACQR (3 year only)	Anniversary date
10	Maintaining Accreditation	Continual

Time Frame at a Glance

Preferred Time Frame	Intent Due to CARF	Expiration Month
*Jul / Aug	Feb 28	Aug
*Jul / Aug	March 31	Sept
Aug / Sept	April 30	Oct
Sept / Oct	May 31	Nov
Oct / Nov	June 30	Dec
Nov / Dec	July 31	Jan
Dec / Jan	Aug 31	Feb
Jan / Feb	Sept 30	March
Feb / Mar	Oct 31	April
Mar / Apr	Nov 30	May
Apr / May or May / June	Dec 31	June

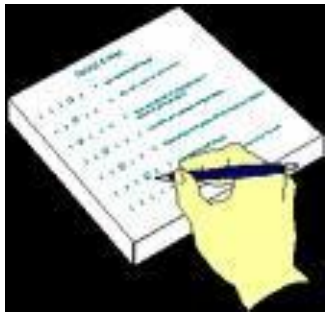
*CARF does not award July expirations

Surveyors

- “Peers” working in the field with a minimum of five years of expertise in direct services or administration
- Trained to provide a consultative survey with a positive expectation for the survey outcome
- Use the same manual
- Review the administration of your organization and the programs you have chosen to include in the accreditation
- Determine conformance with the standards through observation, interview and review of documentation during the survey.

Standards Rating Scale

- A rating scale applied to each standard to assess the degree of conformance
  - 3 - Exemplary Conformance
  - 2 - Acceptable Level of Conformance
  - 1 - Partial Conformance with Substantial Room for Improvement
  - 0 - Nonconformance



Survey Preparation

Kathy Lauerman

- Contact your Resource Specialist
- Acquire the correct standards manual and read it repeatedly
- Allow ample time to get ready
- Conduct staff training – Accreditation is a team effort
- Use the standards manual to identify required written documentation
- Organize your P & P to reflect how you do business

TIPS

Cross walk to Standards
Use words from the standards manual
Seek clarity and accuracy of documentation

- Simplify, simplify, and then simplify again

Typical Survey Schedule

DAY 1	
8:00	Surveyors Arrive
8:30	Orientation Conference
9:00	Facility Tour – Interviews with Board or other Key Stakeholders
9:30	Documentation review, program visits, interviews with staff and persons served
4:30 – 5:00	Surveyors return to hotel to work

DAY 2	
8:30	Surveyors continue review of documentation and complete interviews
1:00	On request Pre-Exit Conference
2:00	Exit Conference (allow min. of one hour)
3:00	Surveyors Depart

Orientation and Exit Conference

Orientation

- Your choice of attendees
- You determine the start time with admin surveyor
- Generally lasts 30-45 minutes
- Introductions of CARF Team and your team
- Have materials organized and “ready to go” after orientation
- Be prepared to “walk” surveyors through personnel and case records

Exit

- Your choice of attendees
- Audio/videotaping allowed
- Generally lasts one hour
- Verbal report of survey findings will focus on recommendations and consultations
- Final opportunity to provide surveyors evidence of standard conformance
- Written report will reflect team’s findings and the outcome award

Accreditation Outcomes

- **Three-year** accreditation – substantial conformance to the standards. Demonstrated improvement from previous periods of CARF accreditation.
- **One-year** accreditation – areas of deficiency, but evidence of capability and commitment.
- **Provisional accreditation** – one year, awarded only ***once,*** after ***one*** year accreditation.
- **Non-accreditation** – numerous and/or major deficiencies in many areas. Serious questions about program benefits, health welfare or safety. (Inability to achieve a three year accreditation following a provisional accreditation)

“What’s the Cost?”

- 2012 Standards Manual - $165
- 2012 Intent to Survey (application fee) - $995
- 2012 Survey Fee (per surveyor per day) - $ 1475

CARF Accreditation Fees - All Inclusive

Average Survey
2 surveyors / 2 days

No: annual fees, membership fees, additional travel fees.

CARF
Standards Manual

The Standards Manual

CARF Information
Policies and Procedures
Changes
STANDARDS
Appendix A: Required Written Documentation
Appendix B: Operational Time Lines
Glossary

Key Definitions

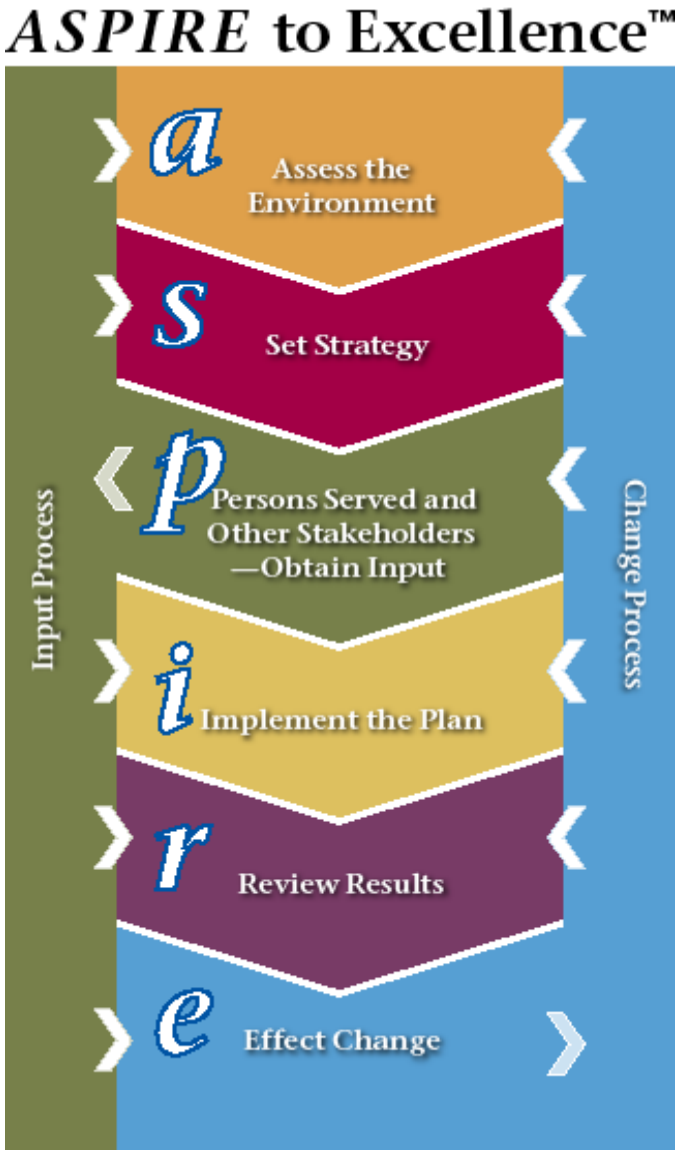
Policy: Written course of action; guidelines adopted by the leadership

Procedure: A “how to” description of actions-to-be-taken. Not written unless specified

Written procedure: Requirement that the procedure is described in writing.

Plan: Written future direction that is action oriented and related to a specific project or defined goal. (Plans for the future)

Section 1: ASPIRE to Excellence®



ASSESS THE ENVIRONMENT

- Leadership
- Governance

SET STRATEGY

- Strategic Integrated Planning

PERSONS SERVED & OTHER STAKEHOLDERS – OBTAIN INPUT

- Input from Person Served and Other Stakeholders

IMPLEMENT THE PLAN

- Legal Requirements
- Financial Planning and Management
- Risk Management
- Health and Safety
- Human Resources
- Technology
- Rights of Persons Served
- Accessibility

REVIEW RESULTS

- Information Measurement and Management

EFFECT CHANGE

- Performance Improvement

BH and CYS
General Program Standards – Section 2

Behavioral Health	Child and Youth Services
Program Structure and Staffing	Program Structure and Staffing
Screening and Access to Services	Screening and Access to Services
Person-Centered Plan	Individualized Plan
Transition / Discharge	Transition / Discharge
Medication Use	Medication Use
Nonviolent Practices	Nonviolent Practices
Records	Records
Quality Records Review	Quality Records Review

BH and CYS Program Standards Sections 3-5

BH:

3. Core Program Standards
4. Specific Population Designation Standards
   - Child and Adolescent
   - Criminal/Juvenile Justice
   - Consumer Run
   - Medically Complex
5. Community and Employment Services

CYS:

3. Specific Program Standards
4. Youth Services Specific Program Standards
5. Specific Population Designation
   - Juvenile Justice
   - Medically Complex

BH and CYS Specific Programs

Assertive Community Treatment	BH	Group Home Care	CYS
Assessment and Referral		Home and Community Services	
Behavioral Consultation	CYS	Intensive Outpatient	
Case Management / Serv. Coord		Inpatient	BH
Child / Youth Protection	CYS	Integrated Behavioral Health	BH
Comm. Housing (Shelters – CYS)		Intensive Family Based Services	
Community Integration	BH	Outpatient / Counseling	
Crisis and Information Call Centers		Partial Hospitalization	BH
Crisis Intervention		Prevention / Diversion	
Crisis Stabilization	BH	Residential	
Court Treatment	BH	Respite	
Day Treatment		Specialized or Tx. Foster Care	CYS
Detox	BH	Support and Facilitation	
Employment Services		Supported Living	
Foster Family and Kinship Care	CYS	Therapeutic Communities	BH

Employment and Community Services Section 2

Employment and Community Services
Program /Service Structure
Individual Centered Service Planning, Design and Delivery
Medication Monitoring and Management
Employment Principles
Workforce Development
Community Services
Child and Adolescent
Older Adult
Medically Fragile

Employment and Community Services Program Standards Sections 3-5

- Section 3 – Employment Services

Emp. Serv. Coordination	Comp. Voc. Evaluation	Personnel Serv. To Employees
Emp. Trans. Serv.	Empl. Skills Training	Affirmative Bus. Enterprise
Targeted Emp. Screening	Community Emp. Serv	Employment Recovery Serv

- Section 4 – Community Services

Community Transition	Personnel Suppport Serv	Vision Rehab
Behavioral Consultation	Self Directed Care Supports	Host Family Services
Autism Supports	Mentor Services	Community Housing

- Section 5 – Psychosocial Rehabilitation Programs

Case Management / Serv Coord	Assessment and Referral
Community Integration	Prevention / Diversion

Why CARF?

- Field driven standards continually reflect best practices
- Choice of programs to be included in survey
- Multiple pathways to conformance – “non-prescriptive”, “non-inspective”
- Surveyors are trained to provide consultation; quality improvement is the goal
- CARF accreditation is “do-able”
- Survey fees are all inclusive and not based on revenue

Resource Specialist – Contact Information

Kathy Lauerman
klauerman@carf.org
(888) 281-6531, ext. 7168

Wrap Up

Questions?

Contact information:

Leslie Ellis-Lang

- lellis-lang@carf.org
- www.carf.org

COA ACCREDITATION

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Objectives

Cover the FAQ's Regarding COA Accreditation

- Process
- Standards
- Unique characteristics
- Cost

COA's Mission

Our mission is to support you

as you strive to fulfill

your mission!

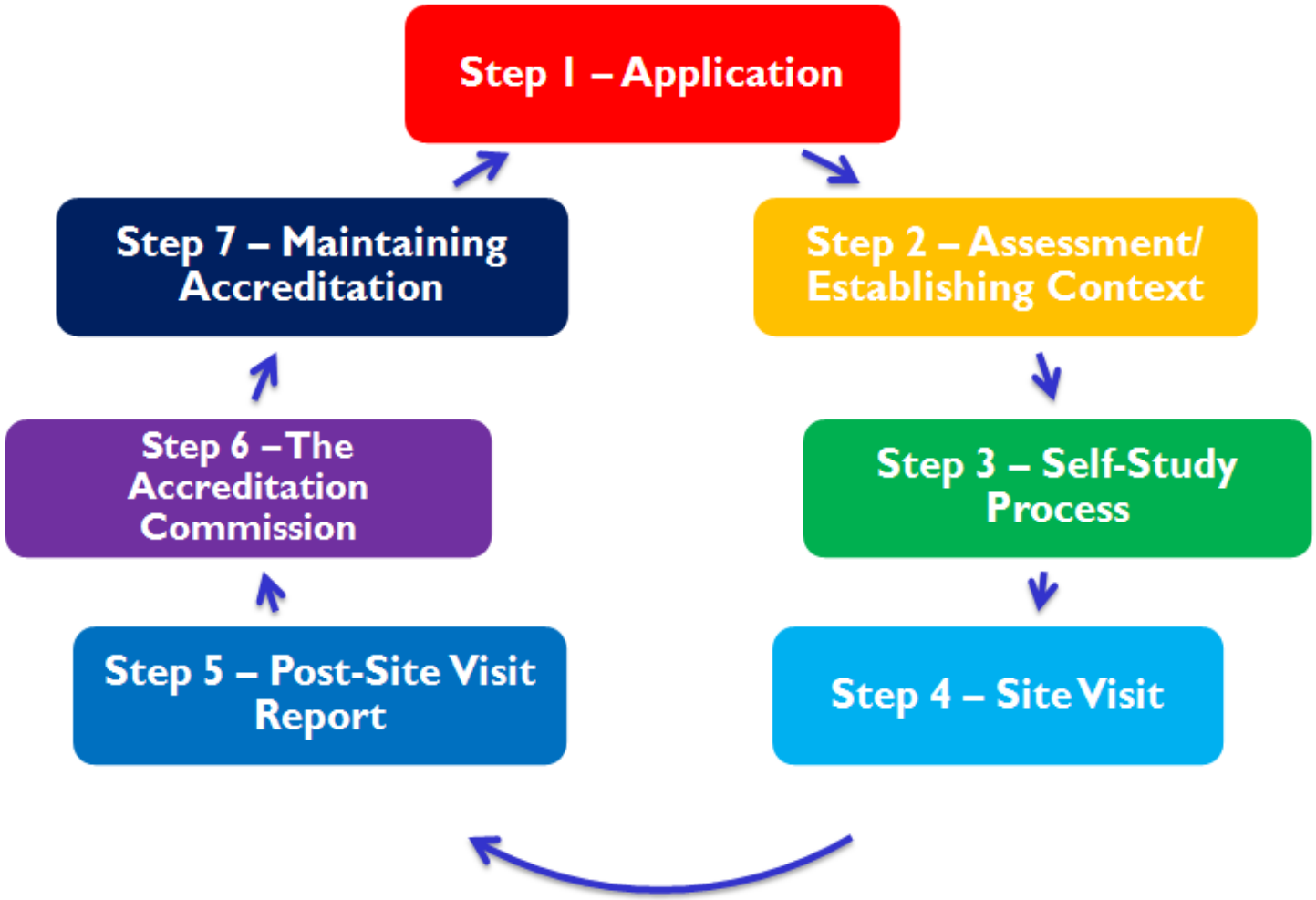
Contextual Accreditation

- A series of rigid rules: *No*
- A licensing add-on: *No*
- An effort to control or limit innovation: *No*
- An attempt to define what you should do or how you should do it: *No*
- A “gotcha” process: *Absolutely Not*

COA's Process & Unique Characteristics

- Open, facilitative, & collaborative process (12-16 months)
  - Develop Self-Study that is reviewed by COA
  - Feedback & support throughout the process
  - Multiple opportunities to show implementation
- Looks at the entire agency – not just a specific service
- Volunteer Peer Reviewers conduct Site Visits
- Accreditation decision made by volunteer Accreditation Commissioners
- Web-based process
- Four year accreditation cycle

COA's Process



COA's Process

Step 1 – Application

- Verification of eligibility
- Accreditation agreement and fee
- Description of rights and responsibilities

Step 2 – Assessment/Intake

- Explanation of the accreditation process
- Understanding of the organization
- Assessment of the organization's readiness
- Match programs to COA's service standards
- Development of an accreditation timetable

COA's Process

Step 3 – Self-Study

- The heart of the accreditation process
- Evaluate practices against national standards
- Develop Self-Study document
- 6-9 months

Step 4 – Site Visit

- 12 weeks after the submission of the Self-Study
- 2-3 peer reviewers for 2-3 days
- Activities
  - Interview staff, board, clients, and other stakeholders
  - Review documents and records
  - Visit programs /Observe staff/Client interactions

COA's Process

Step 5 – Ratings Report

- Summarizes important findings
- Identifies specific recommendations

Step 6 – Accreditation Commission

- Reviews site visit report and organization's response
- Makes accreditation decision

Step 7 – Maintaining Accreditation

- Maintain and sustain implementation
- Complete an Annual Maintenance of Accreditation Report

www.COAstandards.org. It's free!

Web-based Home of the *8th Edition Standards*

Services We Accredit

- Child and Family Services
- Mental Health Services
- Substance Abuse /Opioid Treatment
- Aging Services
- Homeless Services
- Services for the Developmentally Disabled
- Juvenile Justice
- Networks/Lead Management Entities
- Financial Education Services
- Intercountry Adoption Services
- After School Programs

Structure of the Standards

The *8th Edition Standards* are divided into three parts:

1. Administration and Management Standards
2. Service Delivery Administration Standards
3. Service Standards

COA's 8th Edition Standards

- Based on extensive literature review and input of expert panels
- Focus on organizational performance and client outcomes
- Core set of administration and management standards
- Currently 47 service standards that are applicable to over 125 types of programs
- Free and web-based

Cost

- All accreditation is a significant financial investment
- It's not the fees but the staff time that can be expensive
- No one national accreditor is always more affordable than another
- Richard's formula for selecting an accreditor:

Dollar cost + alignment with your agency's philosophy, culture, capacity + type & number of services you provide + convenience = Best Choice

Cost

- Application Fee $750
  - First time applicants only
- Accreditation Fee
  - Sliding fee scale based on organization's revenue
  - Fees start at $6,720 for organizations with revenue* of $500,000 or less *regardless of the number of services provided*
    - COA deducts pass through funds: emergency assistance, foster care payments, funds for contracted providers, revenue for programs not included in the review via our exemption policy or where COA accreditation does not apply or a service is already accredited
  - 25% discount for members of sponsoring organizations

Cost

- Site visit fee
  - Varies depending on the number of sites and the number of services
  - Site visits are a minimum of two peers for two days
  - Flat fee of $2,000 per peer reviewer for a two-day on-site review, plus $425 per day times the number of reviewers for each additional day

- Maintenance of accreditation fee
  - There is an annual MOA fee of $400 for the three years between cycles ($400 x 3 years = $1,200)

Cost

Fee	Type
$750	Application Fee
$6,720	Accreditation Fee (org with revenue of <$500,000)
$4,000	Site Visit Fee (2 Peers for 2 days)
$1,200	MOA Fees
$12,670	**for 4 year accreditation or $3,168 per year**

Now What?

- Questions/comments
- Request a cost estimate
- View the standards online (they're free!)
- Attend a complimentary webinar
- Contact person at COA for LA Providers:

  Zoë Hutchinson, zhutchinson@coanet.org and

  (866) 262-8088, extension 242

Thank You!

Richard Klarberg, President and CEO, rklarberg@coanet.org
Zoë Hutchinson, Manager of Client and Sponsor Relations, zhutchinson@coanet.org
or call *toll free*
(866)262-8088
Richard: Extension 260 or Zoë: Extension 242

www.COAnet.org

Claims

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Claims Requirements

- All claims for covered services provided to Members must be submitted to and received by Magellan as follows:
  - Within one hundred eighty (180) days from date of service for most levels of care except as provided below;
    - Within sixty (60) days from date of discharge for 24/hr level of care;
    - Within sixty (60) days of the last day of the month or the discharge date, whichever is earlier when billing monthly for longer treatment episodes of care at a 24/hr level facility;
    - Within sixty (60) days of the claim settlement for third party claims. This date is based on the date of the other carriers EOB that should be attached to the claim you submit to Magellan.

❖ ***If Magellan does not receive a claim within these timeframes, the claim will be denied.***

Claims Tips

Accepted Methods for Submission of Claims:

- Paper Claims: CMS-1500 (Non-Facility-Based Providers) or UB-04 (Facility-Based Providers)
- Electronic Data Interface (EDI) via Direct Submit
- Electronic Data Interface (EDI) via a Third Party Clearinghouse
  - MBH Clearinghouse ID: 01260
- *Claims Courier* - Magellan's Web-based Claims submission tool (www.MagellanHealth.com)

Claims Tips

- Here are some basic billing tips to get you started:

  www.MagellanHealth.com/provider and go to “Getting Paid”

- On Magellan’s Provider Website you will find information on:

Getting Paid
Preparing Claims – Claims Filing Procedure, Elements of a Clean Claim, Claims Do’s, Claims Don’ts, and Coordination of Benefits
HIPAA – Coding Information on Professional Services, Facility/Program Services, Where do I find Code Sets?, Security, and Resources
Electronic Transactions – 3 Options to submit transactions/claims electronically to Magellan, Companion Guides, Clearinghouse Information, Electronic Funds Transfer, and National Provider Identifiers (NPI)
Paper Claim Forms – CMS-1500 (for non-facility based professional services) and UB-04 (for facility-based professional services)

Electronic Claims: What's in it for You?

- Improved Efficiency
  - No paper claims. No envelopes. No stamps.
  - Prompt confirmation of receipt or incomplete claim
- Faster Reimbursement - cut out the mailman
- Improved Quality
  - Up-front electronic review ensures higher percentage of clean claims
  - Secure process with encryption keys, passwords, etc.

Electronic Claims Submission Options

Which option is best for you?

- **Claims Courier - Magellan's Web Option**
  - For smaller-volume submitters
  - It's free!
  - Web-based, just go to www.MagellanHealth.com/provider
  - Manually key info like you would a CMS-1500 form
  - Info is saved and can be copied for new dates of service
- **Direct Submission to Magellan**
  - For medium to high volume submitters
  - It's free!
  - Send HIPAA compliant transactions (claims) directly to Magellan using your existing software
- **Clearinghouse**
  - For larger volume submitters
  - Magellan works with seven preferred clearinghouses, which accept both professional (CMS-1500) and institutional (UB-04) claims
  - Commonly tie in with practice management software
  - Check with each clearinghouse for their fees

Electronic Transaction Demos on the Magellan Provider Website

- Go to www.MagellanHealth.com/provider
- Choose “Education” from the top menu
- Select “Online Training” from the drop-down menu
- The section on “Electronic Transactions” includes the following:
  - 835 Transactions
  - Clearinghouse
  - EDI Testing Center
  - Electronic Funds Transfer
  - Submit EDI Claims

Claims Contact Information

- General claims questions, contact National Provider Services Line at (800) 788-4005
- EDI Technical Assistance:
  - Getting started, visit our EDI Testing Center at www.edi.MagellanProvider.com
  - Contact EDI Hotline (800)450-7281 x75890 or e-mail EDISupport@MagellanHealth.com

Outcomes and Provider Profiles

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Outcomes: What will be Different

- Continue to meet federal and state reporting requirements
- New Measures (state requirements) e.g. CANS
- Increased transparency regarding system performance (dashboards, regional reports, special topics)
- Development with stakeholders of “dashboards” and other reports

Evolving the Outcomes System

Year 1

- Develop reports with existing data
- Establish stakeholder steering committee(s) to develop outcomes dashboards (child, adult)
- Sharing data with providers and getting feedback

Year 2

- Implement and refine dashboards and other reports with providers and stakeholders
- Implement final versions for public access

Outcomes and Provider Profiles: Sample

Provider Access to and Use of Data

- You will have access to your own data
- You will see a comparison to all providers within your type
- You will be able to:
  - Drill down to individual level data
  - Download your own data into excel
  - Use the information for quality improvement activities
- We will provide technical assistance
  - Webinars
  - How to understand reports
  - How to use for quality improvement activities

Systems Dashboard Development: Year Two

Year One (Q3): Stakeholder steering committee

Year Two: Systems outcomes dashboards (child and adult)

- Clinical
  - Functional outcomes
- Coordination of care
  - Access to services
- Recovery and resiliency
  - Quality of life
- Accountability
  - Safety
  - Integrated behavioral and physical health

Quality

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Quality Activities

Promoting Quality through Partnership

Our purpose is to promote quality through collaboration and partnership. We will achieve this by assigning trained and skilled Quality Reviewers to:

- Provide providers with individualized technical assistance and training
- Improve provider quality through jointly established indicators and outcomes measures
- Show providers how to use data outcomes, record review findings and provider profile results to improve quality
- Work collaboratively with providers on the development of realistic, “doable” action plans

Records Requirement for Medicaid Providers

- Medical records shall be complete and legible for each service for which a charge is made.
- Documentation of each service and activity billed and identification of member by first and last name.
- Evidence that service is medically necessary, consistent with the diagnosis of the member's condition and is consistent with professionally recognized standards of care.
- Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name somewhere within the record.
- Basis for service includes documentation of: member's complaint or symptoms, history, examination findings, diagnostic tests results, goals identified in plan of care, observer's assessment, clinical impression, diagnosis, including date of observation and identity observer.

Maintenance of Records by Providers of Service

- Each service date includes documentation of specific treatments or procedures performed, date, start and ending time of service, location where service provided, name, dosage and route of administration of any medication administered, name and title and signature of provider completing service.
- Documentation of outcome of service including; member's progress in response to services provided, changes in treatment, alteration of the plan of care or revision of diagnosis.
- Records must be provided upon request and before the end of the on-site review or audit.
- Records, financial and medical, are retained for 5 years for Medicaid purposes and for Magellan purposes are 7 years from the last date of service or 7 years from age of majority if the last date of service was when the individual was a minor.

Fraud, Waste and Abuse

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Fraud, Waste and Abuse Overview

- As a Magellan provider, the services that you offer our members are subject to both federal and state laws and contract requirements designed to prevent fraud, waste and abuse in government programs (such as Medicare and Medicaid) and private insurance.

- You can find definitions, examples and ways to prevent fraud in Magellan's fraud, waste and abuse FAQs on Magellan's Provider Website www.MagellanHealth.com/Pprovider and go to "Education" and "Fraud, Waste, and Abuse".

Fraud, Waste and Abuse Overview

- The most serious violation in this category is health care fraud, which is the intentional deception or misrepresentation made by an individual, knowing that the misrepresentation could result in some unauthorized benefit to them or to others. The most common kind of health care fraud involves false statements or deliberate omission of information that is critical in the determination of authorization and payment for services. Health care fraud can result in significant monetary liabilities and, in some cases, subject the perpetrator to criminal prosecution.
- We have a comprehensive compliance program in place, including policies and procedures to address the prevention of fraud, waste and abuse. Magellan, in conjunction with appropriate government agencies, actively pursues all suspected cases of fraud, waste and abuse.
- If you think you have detected an instance of either health care fraud or medical identity theft, please contact the Special Investigations Unit (SIU). The SIU can be reached through a 24-hour Fraud Hotline at 1-800-755-0850 or e-mail sent to SIU@MagellanHealth.com.

Louisiana Training and Technical Assistance Center: Proposed Plan

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Louisiana Training and Technical Assistance Center: Proposed Plan

- Magellan commitment to workforce development and sustainability
- Support of a "culture of quality"
- Clinical and management training
- “Skill-building” for consumers, families and other stakeholders
- Collaborative relationship with Louisiana universities and institutes of higher learning

Louisiana Training and Technical Assistance Center: Development and Implementation

Year 1

- Collaboration with and guidance from the state
- Convening stakeholders and university representatives to identify needs, develop options and priorities
- Develop a plan for implementation

Year 2

- Phase I implementation of plan

Clinical Advisor

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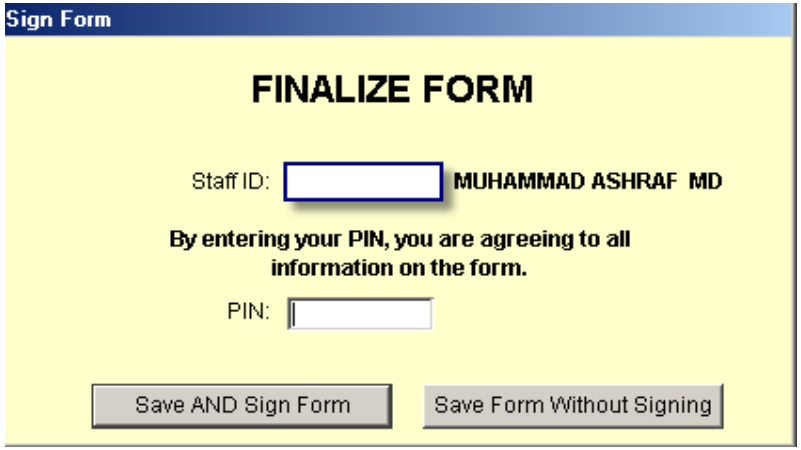
Clinical Advisor Overview

- Clinical Advisor is a web-based Practice Management / Electronic Behavioral Health Record application provided by Magellan for use by contracted providers.
- Clinical Advisor requires no software on the desktop, supports all clinical interactions necessary with the patient, and also provides standard office functionality such as scheduling and claims processing
- Clinical Advisor provides a ‘single view of the truth’ with regard to the patient record. It can be used by multiple agencies all serving the same patient.

Clinical Advisor Features and Functionality

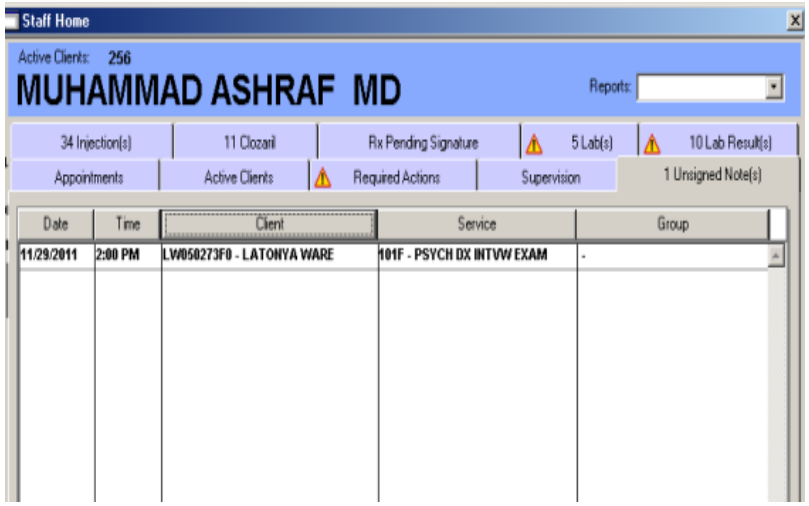
Security

- Browser-based Presentation
- Role-based Security
- Facility-based Security
- User assigned identification (PIN)



Alerts

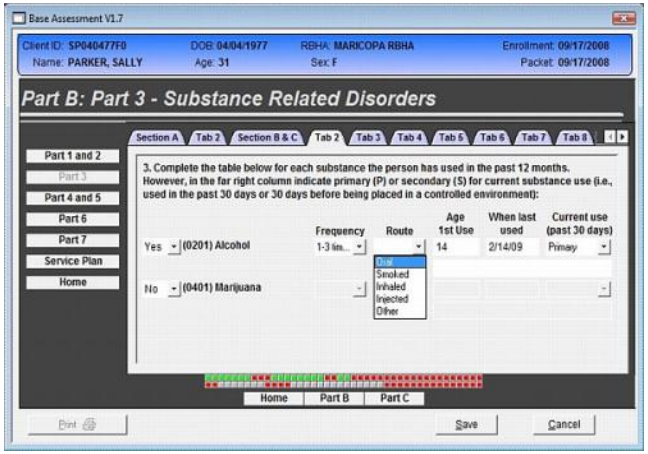
- COT Adherence
- Medication Alerts
- Lab Tests, Results
- User-configurable
- Document Aging/Tracking



Clinical Advisor Features and Functionality

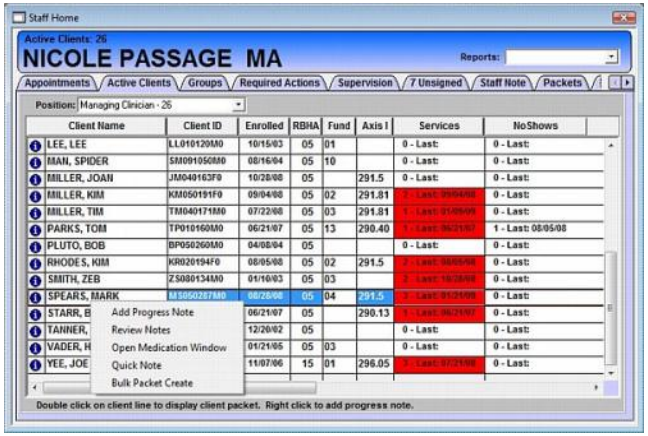
Providers

- Referral to services
- Intake and ongoing assessments
- Service completion
- Treatment planning
- Progress notes



Staff

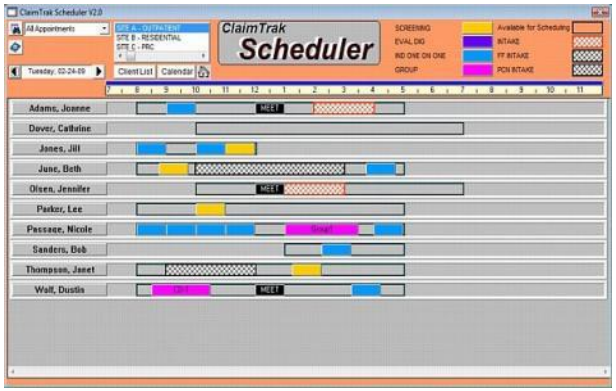
- Daily schedule
- Hierarchy Configuration
- Active client list
- Assigned required action
- Staff is driven to focus on work requiring action



Clinical Advisor Features and Functionality

Scheduler

- Member appointment scheduling for single or multiple appointments
- Can be broken down by site, staff, or client



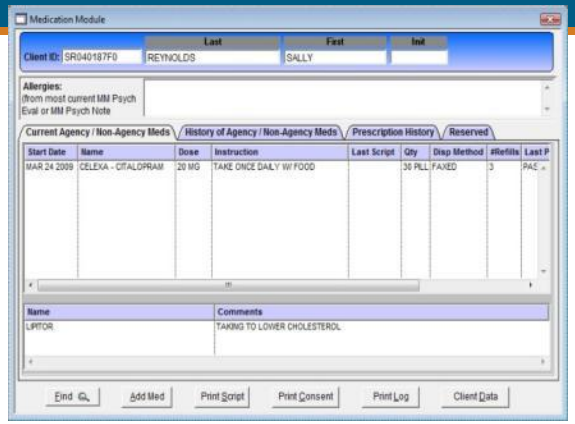
Reporting

- Reporting is available from the EMR and the data warehouse

Clinical Advisor Features and Functionality

Medication Management

- Prescribed medication is tracked to the member and subscriber level
- Medication subscribed elsewhere is entered and incorporated into the EHMR
- Option for ePrescribing and lab interfacing

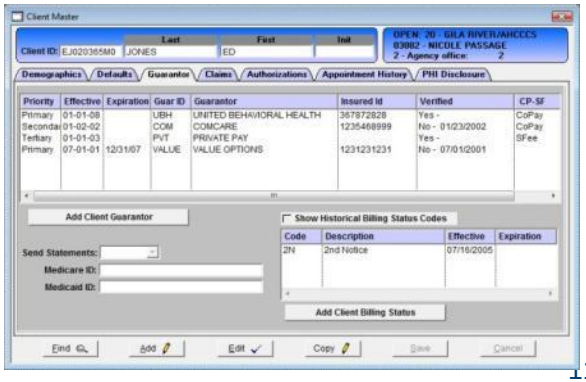


Document Scanning

- Scan core documents into system
- Scanning of doctor and nurse based notes at the individual staff level so that they need not interact with the application
- Scanned nurse or doctor based note becomes a claim

Billing

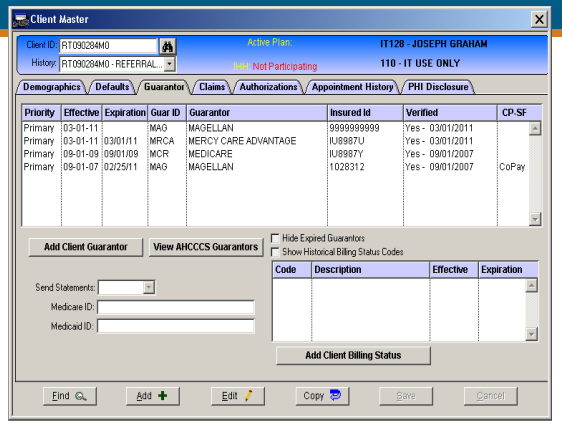
- Medicare and Medicaid
- Multiple-payer third party coordination of benefits



Clinical Advisor Features and Functionality

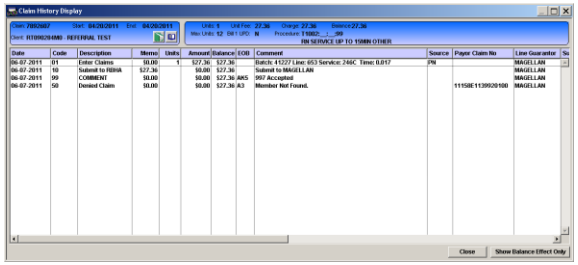
Coordination of Benefits

- Submit Electronic Medicare, Commercial and Medicaid claims
- Manage Primary, Secondary & Tertiary payors
- Manage and track third-party reimbursement



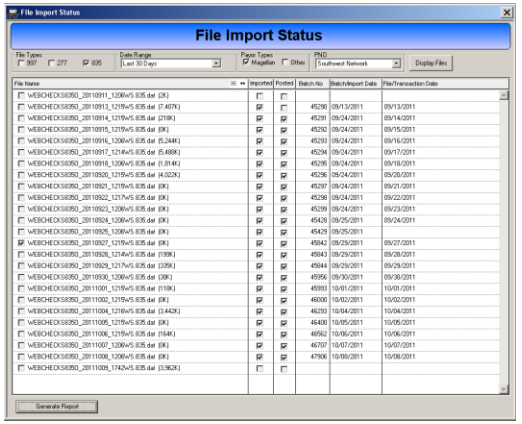
Claim Lifecycle Management

- Automatic claim generation from encounters
- Manage claim lifecycle management with automated importing of EDI response files
- Easily manage denials, rejects, partial payments with reporting tools



Accounts Revenue, Revenue Accrual

- Financial reporting with export to Excel for additional data analysis
- Reconciliation reporting to compare ClaimTrak with CAPS financials



Wrap Up

- Questions?